		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040345

Facility Name: Joshua Manor

Address: 100 West Locust Street (Number) Hoyleton (City) 62803 (Zip Code)

County: Washington

Telephone Number: (618) 493-6071 **Fax #** (618) 493-6145

IDPA ID Number: 371238076007

Date of Initial License for Current Owners: 05/01/93

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/01 to 06/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser, LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,703			5,703	13
14	TOTALS	5,703			5,703	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.65%

D. How many bed-hold days during this year were paid by Public Aid?
55 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/30/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/02 Fiscal Year: 06/30/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	24,048	1,901	1,538	27,487		27,487		27,487			1
2	Food Purchase		23,490		23,490		23,490	(3,331)	20,159			2
3	Housekeeping		632		632		632		632			3
4	Laundry		1,485		1,485		1,485		1,485			4
5	Heat and Other Utilities			10,979	10,979		10,979		10,979			5
6	Maintenance	11,692		5,423	17,115		17,115	33	17,148			6
7	Other (specify):*											7
8	**TOTAL General Services**	35,740	27,508	17,940	81,188		81,188	(3,298)	77,890			8
	B. Health Care and Programs											
9	Medical Director			900	900		900		900			9
10	Nursing and Medical Records	201,040	4,059	2,596	207,695		207,695		207,695			10
10a	Therapy											10a
11	Activities		2,522	5	2,527		2,527		2,527			11
12	Social Services			2,048	2,048		2,048		2,048			12
13	Nurse Aide Training											13
14	Program Transportation			1,502	1,502		1,502		1,502			14
15	Other (specify):* Routine Dental			1,003	1,003		1,003		1,003			15
16	**TOTAL Health Care and Programs**	201,040	6,581	8,054	215,675		215,675		215,675			16
	C. General Administration											
17	Administrative	14,713		62,700	77,413		77,413	5,700	83,113			17
18	Directors Fees							4,576	4,576			18
19	Professional Services			370	370		370	9,937	10,307			19
20	Dues, Fees, Subscriptions & Promotions			1,596	1,596		1,596	47	1,643			20
21	Clerical & General Office Expenses		4,580	5,242	9,822		9,822	2,754	12,576			21
22	Employee Benefits & Payroll Taxes			21,173	21,173		21,173	21,300	42,473			22
23	Inservice Training & Education			43	43		43		43			23
24	Travel and Seminar			623	623		623	475	1,098			24
25	Other Admin. Staff Transportation			1,265	1,265		1,265	265	1,530			25
26	Insurance-Prop.Liab.Malpractice			(751)	(751)		(751)	4,669	3,918			26
27	Other (specify):*											27
28	**TOTAL General Administration**	14,713	4,580	92,261	111,554		111,554	49,723	161,277			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	251,493	38,669	118,255	408,417		408,417	46,425	454,842			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Joshua Manor #0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			17,400	17,400		17,400	259	17,659			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			41,679	41,679		41,679	2,118	43,797			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,397	3,397		3,397	11	3,408			35
36	Other (specify):*											36
37	**TOTAL Ownership**			62,476	62,476		62,476	2,388	64,864			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							444	444			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			26,652	26,652		26,652	8,884	35,536			42
43	Other (specify):* Nonallowable Costs			163,842	163,842		163,842	(163,842)				43
44	**TOTAL Special Cost Centers**			190,494	190,494		190,494	(154,514)	35,980			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	251,493	38,669	371,225	661,387		661,387	(105,701)	555,686			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(160,648)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(499)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(1,770)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,695)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Out of period legal fees	(170)	19		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (165,782)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	60,081		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 60,081		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (105,701)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Joshua Manor

ID# 0040345

Report Period Beginning: 07/01/01

Ending: 06/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Joshua Manor # 0040345 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	33	0	0	0	0	0	0	0	0	0	33	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	33	0	0	0	0	0	0	0	0	0	33	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	5,700	0	0	0	0	0	0	0	0	5,700	17
18	Directors Fees	0	953	3,623	0	0	0	0	0	0	0	0	4,576	18
19	Professional Services	0	2,354	7,753	0	0	0	0	0	0	0	0	10,107	19
20	Fees, Subscriptions & Promotions	0	43	4	0	0	0	0	0	0	0	0	47	20
21	Clerical & General Office Expenses	0	1,964	790	0	0	0	0	0	0	0	0	2,754	21
22	Employee Benefits & Payroll Taxes	0	11,090	6,879	0	0	0	0	0	0	0	0	17,969	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	62	413	0	0	0	0	0	0	0	0	475	24
25	Other Admin. Staff Transportation	0	253	12	0	0	0	0	0	0	0	0	265	25
26	Insurance-Prop.Liab.Malpractice	0	38	4,631	0	0	0	0	0	0	0	0	4,669	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	16,757	29,805	0	0	0	0	0	0	0	0	46,562	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	16,790	29,805	0	0	0	0	0	0	0	0	46,595	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Joshua Manor # 0040345 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	259	0	0	0	0	0	0	0	0	0	259	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,770)	288	3,600	0	0	0	0	0	0	0	0	2,118	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	11	0	0	0	0	0	0	0	0	0	11	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,770)	558	3,600	0	0	0	0	0	0	0	0	2,388	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	444	0	0	0	0	0	0	0	0	0	444	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	8,884	0	0	0	0	0	0	0	0	8,884	42
43	Other (specify):*	(163,842)	0	0	0	0	0	0	0	0	0	0	(163,842)	43
44	**TOTAL Special Cost Centers**	(163,842)	444	8,884	0	0	0	0	0	0	0	0	(154,514)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(165,612)	17,792	42,289	0	0	0	0	0	0	0	0	(105,531)	45

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Progressive Housing, Inc.	100	See attached Related Party Schedule		See attached Related Party Schedule		
See attached Schedule 7A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Repairs & maintenance	$	Center for Residential Management, Inc.	**	$ 33	$ 33	1
2	V	18	Board fees		Center for Residential Management, Inc.	**	953	953	2
3	V	19	Professional fees		Center for Residential Management, Inc.	**	2,354	2,354	3
4	V	20	Licenses, dues, & subs		Center for Residential Management, Inc.	**	43	43	4
5	V	21	Office supplies & telephone		Center for Residential Management, Inc.	**	1,964	1,964	5
6	V	22	Emp. benefits & payroll taxes		Center for Residential Management, Inc.	**	11,090	11,090	6
7	V	24	Travel & seminar		Center for Residential Management, Inc.	**	62	62	7
8	V	25	Vehicle expense		Center for Residential Management, Inc.	**	253	253	8
9	V	26	Vehicle, fire & liab insurance		Center for Residential Management, Inc.	**	38	38	9
10	V	30	Depreciation		Center for Residential Management, Inc.	**	259	259	10
11	V	32	Interest expense		Center for Residential Management, Inc.	**	288	288	11
12	V	35	Vehicle lease		Center for Residential Management, Inc.	**	11	11	12
13	V	39	Ancillary service centers		Center for Residential Management, Inc.	**	444	444	13
14	Total			$			$ 17,792	$ * 17,792	14

** Center for Residential Management, Inc. is Progressive Housing, Inc.'s parent company.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule VII - Related Parties **Related Party Schedule**
Page 6, Section A, Column 2, Related Nursing Homes

Name	Facility Name	City
Progressive Housing, Inc.	Gateway Terrace	Irvington
	Aviston Terrace	Aviston
	Briarbrook Place	East Peoria
	Joshua Manor	Hoyleton
	Terra Estates	Hoyleton
	Park Place	Pana
	Harris Place	East Peoria
	Okawville	Okawville
	Billy Goat Hill	Mt. Vernon
	Country Club Hills (185th St.)	Country Club Hills
	Country Club Hills (Lee St.)	Country Club Hills
	Galaxy	Woodlawn
	Perrine	Centralia
	Troy	Troy
	Western Gardens	Mt. Vernon
	Cardinal	Woodlawn
Residential Centers, Inc.	Lakeview Living Center	Chicago
	Countryview Living Center	Latham
	Sparta Terrace	Sparta
	Taylorville Terrace	Taylorville
	Ellner Terrace	Evansville
Caravilla Resident Centers, Inc.	Mt. Vernon Care Center	Mt. Vernon
	Jeffersonian Care Center	Mt. Vernon
	Casey Care Center	Mt. Vernon

Schedule VII, Related Parties
Page 6, Section A, Column 3, Other Related Business Entities

Name	City	Type of Business
Center for Residential Management, Inc.	Peoria	Management/Holding Co.
Residential Centers, Inc.	Peoria	ICF/DD Provider
Progressive Housing, Inc.	Peoria	ICF/DD Provider
Caravilla Charitable Corporation	Mt. Vernon	Lessor
Caravilla Resident Centers, Inc.	Mt. Vernon	SNF/ICF Provider

See Accountants' Compilation Report

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Administrative service fees	$	Progressive Housing, Inc.	100.00%	$ 5,700	$ 5,700	15
16	V	18	Board fees		Progressive Housing, Inc.	100.00%	3,623	3,623	16
17	V	19	Professional fees		Progressive Housing, Inc.	100.00%	7,753	7,753	17
18	V	20	License, dues & subscriptions		Progressive Housing, Inc.	100.00%	4	4	18
19	V	21	Office supplies & telephone		Progressive Housing, Inc.	100.00%	790	790	19
20	V	22	Emp. benefits & payroll taxes		Progressive Housing, Inc.	100.00%	6,879	6,879	20
21	V	24	Travel & seminar		Progressive Housing, Inc.	100.00%	413	413	21
22	V	25	Vehicle expense		Progressive Housing, Inc.	100.00%	12	12	22
23	V	26	Vehicle, fire & liab insurance		Progressive Housing, Inc.	100.00%	4,631	4,631	23
24	V	32	Interest expense		Progressive Housing, Inc.	100.00%	3,600	3,600	24
25	V	42	Provider fees		Progressive Housing, Inc.	100.00%	8,884	8,884	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 42,289	$ * 42,289	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Cora Flota	Director	Board Member	None	4,247	2 hrs/mtg		Directors Fees	$ 553	L18,C8	1
2	Darrell Boehne	President	Board Member	None	14,666	2 hrs/mtg		Directors Fees	734	L18,C8	2
3	Edward Childers	Vice President	Board Member	None	14,484	2 hrs/mtg		Directors Fees	716	L18,C8	3
4	Kay Schuman Johnson	Director	Board Member	None	2,118	2 hrs/mtg		Directors Fees	282	L18,C8	4
5	Orland Bauer	Treasurer	Board Member	None	9,689	2 hrs/mtg		Directors Fees	711	L18,C8	5
6	Ron Schroeder	Secretary	Board Member	None	14,689	2 hrs/mtg		Directors Fees	711	L18,C8	6
7	Merla McCloud	Recorder	Administrative	None	17,689	2 hrs/mtg		Directors Fees	711	L18,C8	7
8	Robert Bauer	Director	Board Member	None	13,842	2 hrs/mtg		Directors Fees	158	L18,C8	8
9											9
10											10
11											11
12	See attached Schedule 7A										12
13								TOTAL	$ 4,576		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SCHEDULE 7A

Board of Directors Fees

	Ron Schroeder	Darrell Boehne	Edward Childers	Bob Bauer	Cora Flota	Orland Bauer	Kay Schuman Johnson	Roger Ryan	Ronald O'Daniell	William Armstrong	Kay Baker	Merla McCloud	Totals
Residential Centers, Inc.													
Lakeview Living Center	3,757	3,606	3,606	3,606								3,606	18,181
Sparta Terrace	415	398	398	398								398	2,006
Ellner Terrace	415	398	398	398								398	2,006
Taylorville Terrace	415	398	398	398								398	2,006
Total RCI	5,000	4,800	4,800	4,800	0	0	0	0	0	0	0	4,800	24,200
Progressive Housing, Inc.													
Aviston Terrace	553	576	553		553	553	282					553	3,623
Harris Place	553	576	553		553	553	282					553	3,623
Briarbrook Place	553	576	553		553	553	282					553	3,623
Joshua Manor	553	576	553		553	553	282					553	3,623
Terra Estates	553	576	553		553	553	282					553	3,623
Park Place	553	576	553		553	553	282					553	3,623
Okawville	207	216	207		207	207	106					207	1,358
Perrine	138	144	138		138	138	71					138	906
Western Gardens	138	144	138		138	138	71					138	905
Galaxy	276	288	276		276	276	141					276	1,811
Billy Goat Hill	276	288	276		276	276	141					276	1,811
Troy	138	144	138		138	138	71					138	906
Country Club Hills - 185th St.	207	216	207		207	207	106					207	1,357
Country Club Hills - Lee St.	101	101	101		101	101	0					101	608
Total PHI	4,800	5,000	4,800	0	4,800	4,800	2,400	0	0	0	0	4,800	31,400
Caravilla Resident Centers, Inc.													
Mt. Vernon				980				871	871	871	871	871	5,338
Jeffersonian Care Center				996				885	885	885	885	885	5,421
Casey Care Center				1,624				1,443	1,443	1,443	1,443	1,443	8,841
Total CRC	0	0	0	3,600	0	0	0	3,200	3,200	3,200	3,200	3,200	19,600
Center for Residential Management, Inc. *	5,600	5,600	5,600	5,600		5,600						5,600	33,600
Total Board of Directors Fees	15,400	15,400	15,200	14,000	4,800	10,400	2,400	3,200	3,200	3,200	3,200	18,400	108,800

* Center for Residential Management, Inc.'s board fees are allocated to each facility.

Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business transactions with the nursing home during the reporting period.

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Center for Residential Management, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional fees	Bed days available	207,498	21	$ 7,680	$	5,840	$ 216	1
2	20	Licenses, dues, & subs	Bed days available	207,498	21	(100)		5,840	(3)	2
3	21	Office supplies & telephone	Bed days available	207,498	21	(861)		5,840	(25)	3
4	24	Travel & seminar	Bed days available	207,498	21	(580)		5,840	(17)	4
5	25	Vehicle expense	Bed days available	207,498	21	8,145		5,840	229	5
6	26	Vehicle, fire & liab insurance	Bed days available	207,498	21	1,353		5,840	38	6
7	30	Depreciation	Bed days available	207,498	21	9,194		5,840	259	7
8	32	Interest expense	Bed days available	207,498	21	8,154		5,840	229	8
9	35	Vehicle lease	Bed days available	207,498	21	375		5,840	11	9
10	39	Ancillary service centers	Bed days available	207,498	21	15,783		5,840	444	10
11										11
12	6	Repairs & maintenance	Direct method						33	12
13	18	Board fees	Direct method						953	13
14	19	Professional fees	Direct method						2,138	14
15	20	Licenses, dues, & subs	Direct method						46	15
16	21	Office supplies & telephone	Direct method						1,989	16
17	22	Emp. benefits & payroll taxes	Direct method						11,090	17
18	24	Travel & seminar	Direct method						79	18
19	25	Vehicle expense	Direct method						24	19
20	32	Interest expense	Direct method						59	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 49,143	$		$ 17,792	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Progressive Housing, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative service fees	Number of beds, direct costs	142	14	$ 41,025	$	16	$ 5,700	1
2	18	Board fees	Number of beds, direct costs	142	14	31,402		16	3,623	2
3	19	Professional fees	Number of beds, direct costs	142	14	66,457		16	7,753	3
4	20	License, dues & subscriptions	Number of beds	142	14	35		16	4	4
5	21	Office supplies & telephone	Number of beds	142	14	6,942		16	790	5
6	22	Emp. benefits & payroll taxes	Number of beds	142	14	1,438		16	169	6
7	24	Travel & seminar	Number of beds	142	14	3,576		16	413	7
8	25	Vehicle expense	Number of beds	142	14	107		16	12	8
9	32	Interest expense	Number of beds, direct costs	142	14	31,230		16	3,600	9
10	42	Provider fees	Number of beds, direct costs	142	14	53,342		16	8,884	10
11										11
12										12
13										13
14										14
15	22	Emp. benefits & payroll taxes	Direct method						6,710	15
16	26	Vehicle, fire & liab insurance	Direct method						4,631	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 235,554	$		$ 42,289	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	IL Health Fac. Auth.-Bonds		x	Acquisition of facility	Various	03/01/93	$ 4,527,000	$ 501,410	08/15/16	Varies	$ 38,059	1
2	NCS Healthcare		x	Hardware/Software	$94.00	10/31/98	3,756	1,299	09/30/03	0.1429	144	2
3												3
4												4
5								Amortization of bond costs			2,487	5
	Working Capital											
6	Community Bank of Galesburg		x	Working Capital	Varies	08/23/02	286,000	26,592	02/23/03	0.0950	2,957	6
7												7
8												8
9	TOTAL Facility Related				$94.00		$ 4,816,756	$ 529,301			$ 43,647	9
	B. Non-Facility Related*											
10							Disallow non-allowable interest & offset interest income				(1,770)	10
11							Parent Company allocation				229	11
12							Finance & Service charges				1,691	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 150	14
15	TOTALS (line 9+line14)						$ 4,816,756	$ 529,301			$ 43,797	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Joshua Manor COUNTY Washington

FACILITY IDPH LICENSE NUMBER 0040345

CONTACT PERSON REGARDING THIS REPORT Rob Keime

TELEPHONE (309) 685-0595 FAX #: (309) 685-8463

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.	N/A		$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,276 B. General Construction Type: Exterior Brick/shingle Frame Wood Number of Stories One

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care	46,100	1993	$ 20,000	1
2					2
3	TOTALS	46,100		$ 20,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1993	1990	$ 406,000	$ 10,150	40	$ 10,150	$	$ 93,042	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1995	1,709	114	15	114		855	9
10	Carpet installation			1996	1,307	87	15	87		609	10
11	Carpet			1996	1,313	88	15	88		526	11
12	Water Heater			1998	608	40	15	40		140	12
13	Tile			1999	849	56	15	56		140	13
14	Shower			1999	2,789	186	15	186		465	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 414,575	$ 10,721		$ 10,721	$	$ 95,777	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 57,055	$ 6,274	$ 6,274	$	5-10 years	$ 39,522	71
72	Current Year Purchases	2,555	131	131		5-10 years	131	72
73	Fully Depreciated Assets	2,072					2,072	73
74	Parent company allocation			259	259			74
75	TOTALS	$ 61,682	$ 6,405	$ 6,664	$ 259		$ 41,725	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	95 Ford E 350 Van	2002	$ 7,230	$ 241	$ 241	$	5	$ 241	76
77	Facility Use	98 Dodge Van	2002	975	33	33		5	33	77
78										78
79										79
80	TOTALS			$ 8,205	$ 274	$ 274	$		$ 274	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 504,462	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 17,400	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 17,659	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 259	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 137,776	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [ ] YES [ ] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 1,584 Description: Wheelchair - $1,000; Cushion - $44; Copier - $540
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident Care	1995 Ford Van	$ 52.00	$ 313	17
18	Resident Care	1993 Dodge Van	125.00	750	18
19	Resident Care	1994 Chevy Corsica	125.00	750	19
20	Parent company allocation			11	20
21	TOTAL		$ 302.00	$ 1,824	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Pt. B Mcr. Supplies	L39, C8					444		444	13
14	TOTAL			$		$	$ 444		$ 444	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,035)	146,568	146,568	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,462	2,462	6
7	Other Prepaid Expenses	14,423	14,423	7
8	Accounts Receivable (owners or related parties)	360,857	360,857	8
9	Other(specify): Prepaid Deposit	6,155	6,155	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 530,465	$ 530,465	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	20,000	13
14	Buildings, at Historical Cost	406,000	406,000	14
15	Leasehold Improvements, at Historical Cost	8,575	8,575	15
16	Equipment, at Historical Cost	69,887	69,887	16
17	Accumulated Depreciation (book methods)	(137,776)	(137,776)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Costs	34,399	34,399	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 401,085	$ 401,085	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 931,550	$ 931,550	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 93,760	$ 93,760	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	45,312	45,312	29
30	Accrued Salaries Payable	22,050	22,050	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	19,267	19,267	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	69,414	69,414	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 249,803	$ 249,803	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,299	1,299	39
40	Mortgage Payable			40
41	Bonds Payable	482,690	482,690	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 483,989	$ 483,989	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 733,792	$ 733,792	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 197,758	$ 197,758	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 931,550	$ 931,550	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Joshua Manor
Provider #0040345
June 30, 2002

Schedule 17A

XV. Balance Sheet

Line 36-Other

	Operating	After Consolidating
Accrued Expense	4,451	4,451
Accrued Bond Payments	22,964	22,964
Resident Credit Balance	3,614	3,614
Accrued Workshop	38,385	38,385
	69,414	69,414

See Accountants' Compilation Report

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 108,246	1
2	Restatements (describe):		2
3	**Prior period audit adjustment**	12,582	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 120,828	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	135,630	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Parent company allocation**	(58,700)	15
16	Other (describe) **added back in column 7**		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 76,930	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 197,758	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 636,290	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 636,290	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	160,648	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 160,648	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	79	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 79	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 797,017	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	81,188	31
32	Health Care	215,675	32
33	General Administration	111,554	33
	B. Capital Expense		
34	Ownership	62,476	34
	C. Ancillary Expense		
35	Special Cost Centers	163,842	35
36	Provider Participation Fee	26,652	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 661,387	40
41	**Income before Income Taxes (line 30 minus line 40)****	135,630	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 135,630	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
A Federal Tax return is filed for the combined divisions of Progressive Housing, Inc.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	446	478	9,718	20.33	3
4	Licensed Practical Nurses	1,573	1,677	20,501	12.22	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,908	3,221	24,048	7.47	15
16	Dishwashers					16
17	Maintenance Workers	1,023	1,149	11,692	10.18	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	718	758	14,713	19.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,548	1,664	25,605	15.39	29
30	Habilitation Aides (DD Homes)	16,908	18,318	145,216	7.93	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	25,124	27,265	$ 251,493 *	$ 9.22	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	24	$ 1,538	L1, C3	35
36	Medical Director	Monthly	900	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	95	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	31	2,048	L12, C3	45
46	Other(specify)				46
47	Psychological Consultant	Monthly	2,501	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	55	$ 7,082		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Alan Cary	Administrator	0%	$ 8,497
Ann Breuer	Administrator	0%	6,216
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 14,713

B. Administrative - Other

Description	Amount
Developmental Services of Illinois, Inc. -	$ 62,700
Administrative Service Fees	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 62,700
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	U/C Consultation	$ 200
Lawrence Manson	Legal	170
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 370

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 6,710
Unemployment Compensation Insurance	1,617
FICA Taxes	19,144
Employee Health Insurance	11,156
Employee Meals	3,331
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	60
Other Employee Benefits	455
TOTAL (agree to Schedule V, line 22, col.8)	$ 42,473

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 3)	21
Illinois Health Care Association	927
Various License & Fees	506
Various Subscription & Dues	192
Parent Company Allocation	(3)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,643

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	824
Seminar Expense	291
Parent company allocation	(17)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,098

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Joshua Manor
Provider #: 0040345
07/01/01 to 06/30/02

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)		370
Allocated from Progressive Housing, Inc.		
Altschuler, Melvoin & Glasser LLP	Accounting	6,283
American Express Tax & Business Services	Accounting	124
Lawrence Manson	Legal	1,346
Allocated from Parent Company		
Altschuler, Melvoin & Glasser LLP	Accounting	399
American Express Tax & Business Services	Accounting	387
Heinold-Banwart	Accounting	678
Lawrence Manson	Legal	890
Less: Out of period legal fees		(170)
Total (agree to Schedule V, line 19, column 8)		10,307

See Accountants' Compilation Report

PROGRESSIVE HOUSING, INC.
LEGAL FEES ALLOCATION
June 30, 2002

Detailed legal invoice listing:

Lawrence Manson	960
Lawrence Manson	460
Lawrence Manson	1,900
Lawrence Manson	1,340
Lawrence Manson	720
Lawrence Manson	300
Lawrence Manson	2,180
Lawrence Manson	3,040
Lawrence Manson	460
	440
	11,800

	Aviston	Briarbrook	Harris	Joshua	Terra	Park	Perrine	Okawville	Western Gardens	Galaxy	Billy Goat Hill	Troy	CCH 185th	CCH Lee St.	Total
# of beds	16	16	16	16	16	16	4	6	4	8	8	4	6	6	142
Lawrence Manson	1,346	1,346	1,346	1,346	1,346	1,346	337	505	337	673	673	337	505	360	11,800
	1,346	1,346	1,346	1,346	1,346	1,346	337	505	337	673	673	337	505	360	11,800

SEE ACCOUNTANTS' COMPILATION REPORT

Center for Residential Management, Inc.
Professional Fees Allocation
June 30, 2002

American Express Tax & Business Services	Accounting	13,626
Altschuler, Melvoin & Glasser LLP	Accounting	14,178
Heinold-Banwart	Accounting	24,092
Lawrence Manson	Legal	31,620
Amount allocated through CRM allocation		83,516

Detailed legal invoice listing

Lawrence Manson	3,260
Lawrence Manson	4,360
Lawrence Manson	1,300
Lawrence Manson	5,600
Lawrence Manson	360
Lawrence Manson	3,420
Lawrence Manson	500
Lawrence Manson	2,540
Lawrence Manson	1,980
Lawrence Manson	2,720
Lawrence Manson	1,700
Lawrence Manson	3,880
	31,620

	Lakeview	Countryview	Sparta	Ellner	Taylorville	Gateway	Aviston	Briarbrook	Harris	Joshua	Terra	Park Place	Perrine	Okawville	WGarden	Galaxy	Cardinal	BGHill	Troy	CCH 185th	CCH Lee St.	Mt. Vernon	Jeffersonian	Casey	TOTAL
bed days available	52,925	-	5,840	5,840	5,840	-	5,840	5,840	5,840	5,840	5,840	5,840	1,460	2,190	1,460	2,920	-	2,920	1,460	2,190	1,638	23,360	23,725	38,690	207,498
Alloc. Percentage	0.255063	0.000000	0.028145	0.028145	0.028145	0.000000	0.028145	0.028145	0.028145	0.028145	0.028145	0.028145	0.007036	0.010554	0.007036	0.014072	0.000000	0.014072	0.007036	0.010554	0.007894	0.112579	0.114338	0.186460	1.000000
American Express Tax & Business Services	3,512	-	387	387	387	-	387	387	387	387	387	387	83	128	80	176	-	176	80	128	92	1,551	1,575	2,568	13,626
Altschuler, Melvoin & Glasser LLP	3,616	-	399	399	399	-	399	399	399	399	399	399	100	150	100	200	-	200	100	150	112	1,596	1,621	2,644	14,178
Heinold-Banwart	6,145	-	678	678	678	-	678	678	678	678	678	678	170	254	170	339	-	339	170	254	190	2,712	2,755	4,492	24,092
Lawrence Manson	8,065	-	890	890	890	-	890	890	890	890	890	890	222	334	222	445	-	445	222	334	250	3,560	3,615	5,896	31,620
	21,339	-	2,354	2,354	2,354	-	2,354	2,354	2,354	2,354	2,354	2,354	575	865	572	1,159	-	1,159	572	865	643	9,419	9,566	15,599	83,516

See Accountants' Compilation Report

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5	N/A												
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 07/01/01 Ending: 06/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $927**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **2,408** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES ____ NO **x** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **35,536**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **Yes** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **3,331** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **50%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin & Glasser LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Joshua Manor
Provider # 0040345
RSD Salary Allocation
06/30/02

Schedule 23A

	Name of RSD	Number of Residents	X	Number of Hours Req'd	X	Weeks per year	=	Total Hours	/	Total hours paid	X	Total RSD Wages per Trial Balance	=	Total Reclassed to RSD (ln 10)	Total Remaining in Administrative Salaries (ln 17)
Joshua	Ann Breuer	16		2		52		1,664		2,068		31,821		25,605	6,216

Rule 350.3740 requires a minimum Resident Services Coordinator staffing of two hours per week per resident. We allocated wages between the Nursing/Programs section of the cost report with the remainder left in Administrative.

See Accountants' Compilation Report

RECONCILIATION REPORT **Joshua Manor** **03:15 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-105,701	equal to	-105,701	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	43,797	equal to	43,797	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	17,659	equal to	17,659	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	3,408	equal to	3,408	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	0	equal to	0	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	444	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	81,188	equal to	81,188	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	215,675	equal to	215,675	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	111,554	equal to	111,554	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	62,476	equal to	62,476	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	163,842	equal to	163,842	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	26,652	equal to	26,652	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	201,040	equal to	201,040	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	0	equal to		0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	0	equal to		0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	24,048	equal to	24,048	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	11,692	equal to	11,692	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	0	equal to		0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	14,713	equal to	14,713	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	0	equal to		0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	251,493	equal to	251,493	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,538	< or = to	1,538	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	900	< or = to	900	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	95	< or = to	2,596	-2,501	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	5	-5	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,048	< or = to	2,048	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	14,713	equal to	14,713	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	62,700	equal to	62,700	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	370	equal to	370	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	42,473	equal to	42,473	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	1,643	equal to	1,643	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1,098	equal to	1,098	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	35,536	equal to	26,652	8,884	FAILED	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	3,331	< or = to	21,300	-17,969	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	3,331	equal to	3,331	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	60,081	equal to	60,081	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	529,301	equal to	529,301	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	N/A	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	20,000	equal to	20,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	414,575	equal to	414,575	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	69,887	equal to	69,887	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	137,776	equal to	137,776	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	197,758	equal to	197,758	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	135,630	equal to	135,630	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	931,550	equal to	931,550	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	24,048	1,901	1,538	27,487	0	27,487	0	27,487
2. Food P	0	23,490	0	23,490	0	23,490	-3,331	20,159
3. Housek	0	632	0	632	0	632	0	632
4. Laundry	0	1,485	0	1,485	0	1,485	0	1,485
5. Heat ar	0	0	10,979	10,979	0	10,979	0	10,979
6. Mainter	11,692	0	5,423	17,115	0	17,115	33	17,148
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	35,740	27,508	17,940	81,188	0	81,188	-3,298	77,890
9. Medical	0	0	900	900	0	900	0	900
10. Nursin	201,040	4,059	2,596	207,695	0	207,695	0	207,695
10a. Thera	0	0	0	0	0	0	0	0
11. Activit	0	2,522	5	2,527	0	2,527	0	2,527
12. Social	0	0	2,048	2,048	0	2,048	0	2,048
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	1,502	1,502	0	1,502	0	1,502
15. Other	0	0	1,003	1,003	0	1,003	0	1,003
16. Total H	201,040	6,581	8,054	215,675	0	215,675	0	215,675
17. Admin	14,713	0	62,700	77,413	0	77,413	5,700	83,113
18. Direct	0	0	0	0	0	0	4,576	4,576
19. Profes	0	0	370	370	0	370	9,937	10,307
20. Fees,	0	0	1,596	1,596	0	1,596	47	1,643
21. Clerica	0	4,580	5,242	9,822	0	9,822	2,754	12,576
22. Emplo	0	0	21,173	21,173	0	21,173	21,300	42,473
23. Inserv	0	0	43	43	0	43	0	43
24. Travel	0	0	623	623	0	623	475	1,098
25. Other	0	0	1,265	1,265	0	1,265	265	1,530
26. Insura	0	0	-751	-751	0	-751	4,669	3,918
27. Other	0	0	0	0	0	0	0	0
28. Total (	14,713	4,580	92,261	111,554	0	111,554	49,723	161,277
29. Total (	251,493	38,669	118,255	408,417	0	408,417	46,425	454,842
30. Depre	0	0	17,400	17,400	0	17,400	259	17,659
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	41,679	41,679	0	41,679	2,118	43,797
33. Real E	0	0	0	0	0	0	0	0
34. Rent -	0	0	0	0	0	0	0	0
35. Rent -	0	0	3,397	3,397	0	3,397	11	3,408
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	62,476	62,476	0	62,476	2,388	64,864
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	0	0	0	0	0	444	444
40. Barbe	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42. Provid	0	0	26,652	26,652	0	26,652	8,884	35,536
43. Other	0	0	163,842	163,842	0	163,842	-163,842	0
44. Total S	0	0	190,494	190,494	0	190,494	-154,514	35,980
45. Grand	251,493	38,669	371,225	661,387	0	661,387	-105,701	555,686

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	0	0
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	146,568	146,568
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	2,462	2,462
7. Other Prepaid Expenses	14,423	14,423
8. Accounts Receivable-Owner/Related Party	360,857	360,857
9. Other (specify):	6,155	6,155
10. Total current assets	530,175	530,175
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	20,000	20,000
14. Buildings, at Historical Cost	406,000	406,000
15. Leasehold Improvements, Historical Cost	8,575	8,575
16. Equipment, at Historical Cost	69,887	69,887
17. Accumulated Depreciation (book methods)	-137,776	-137,776
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	34,399	34,399
24. Total Long-Term Assets	401,085	401,085
25. Total Assets	931,260	931,260
CURRENT LIABILITIES		
26. Accounts Payable	93,760	93,760
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	45,312	45,312
30. Accrued Salaries Payable	22,050	22,050
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	19,267	19,267
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	69,414	69,414
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	249,513	249,513
LONG TERM LIABILITES		
39.Long-Term Notes Payable	1,299	1,299
40.Mortgage Payable	0	0
41.Bonds Payable	482,690	482,690
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	483,989	483,989
46.Total Liabilities	733,502	733,502
47.Total Equity	197,758	197,758
48.Total Liabilities and Equity	931,260	931,260

		Balance per Medicaid Trial Balance
1.	Gross F	636,290
2.	Discour	0
	Subtota	636,290
4.	Day Ca	0
5.	Other C	0
6.	Therapy	0
7.	Oxygen	0
	Subtota-	
9.	Paymer	160,648
10.	Other	0
11.	Nurses	0
12.	Gift an	0
13.	Barber	0
14.	Non-P	0
15.	Telepl	0
16.	Rental	0
17.	Sale o	0
18.	Sale o	0
19.	Labora	0
20.	Radiol	0
21.	Other	0
22.	Laund	0
	Subtot	160,648
24.	Contril	0
25.	Interes	79
	Subtot	79
27.	Other	0
28.	Other	0
	Subtot-	
30.	Total F	797,017
31.	Gener	680,120
32.	Health	1,154,988
33.	Gener	668,561
34.	Owner	144,710
35.	Specia	60,174
35.	Provid	41,063
37.	Other	0
40.	Total E	2,749,616
41.	Incom	########
42.	Incom	0
43.	Net In	########

Page

Line 16 for mortgage insurance.